APPROVED PA Criteria DUR July 2012

Effective Date: July 11, 2012

CRITERIA FOR PRIOR AUTHORIZATION

Firazyr (icatibant)

PROVIDER GROUP: Pharmacy, Professional

MANUAL GUIDELINES: The following drug(s) require(s) prior authorization:

Firazyr® (icatibant)

CRITERIA: (must meet all of the following)

- Have diagnosis of hereditary angioedema (HAE)
- Used for the treatment of an acute attack of HAE
- Be 18 years of age or older
- Patient must be trained by a healthcare professional on self-administration

Prior Authorization will be approved for six (6) months.